those of the primary attack, are less extensive.

It is very difficult to give a satisfactory explanation of these relapses. Some claim that they are the result of certain plans of treatment, especially the cold-water plan. This assertion lacks proof. Again, others hold that all relapses depend upon a new infection. Perhaps this is possible if the patient remain in the same locality and has the same surroundings as when he had the primary attack; but how shall we explain relapses in those who are removed from all the sources of the primary infection? Another explanation offered is, that a part of the typhoid poison has remained in the system, undeveloped during the primary attack, and that some time after this has passed the poison reproduces itself and sets up a second fever.

A more recent theory is, that the tyhoid poison thrown off in the fæces of the patient is reabsorbed and causes the relapse. Unquestionably, it is possible for healthy glands to become inoculated by sloughs thrown off from those first affected.

In many cases it is impossible to account for the occurrence of the relapse, and all of these explanations as to the cause in any case are more or less unsatisfactory.

In thoses cases which have come under my own observation, I have noticed that the splenic enlargement which has existed during the course of the fever does not subside with its decline; and that the tenderness along the line of the intestines, especially in the right iliac region, continues during the period between the original attack and the relapse. In some instances, apparently, the relapse has been brought on by indiscretion in diet, or by injudicious exercise on the part of the convalescent patient. Occasionally relapses have occurred when great care had been taken against any indiscretion or over-exertion.—*New York Medical Record.*

PUERPERAL FEVER AND SEPTICÆMIA.

Dr. Geo. Hunter read before the Medico-Chirurgical Society of Edinburgh (British Med. Journal, September 23, 1876) a paper on Puerperal Fever and Septicæmia, their relations and probable identity, with cases. He first alluded to the difficulty felt by the practitioner in publishing cases of puerperal fever; and then described some cases in his ordinary practice which preceded the puerperal ones. Two were in the same house; the husband had diffuse cellulitis of the arm after a puncture which nearly proved fatal, and his wife had a very bad attack of erysipelas. Other cases of erysipelas had large abscesses and great fetor, and one especially required very constant dressing and care by Dr. Hunter's own hands. The puerperal-fever cases were six in number, of which four died and two recovered. These cases were coincident with some most curious and serious results on the health of their nurses and families. *E.g.*, the mother of one, who nursed her, had axillary abscess of a most severe type, with great prostration. Her sister, who succeeded her mother as nurse, had a most dangerous inflammation of finger, hand, and arm. The servant-girl, who washed the linen, had fever and sore-throat, and the husband a slighter form of the same in his tonsils. Another case similarly affected her mother, husband, three sisters-in-law, who all acted as nurses successively, and the husband of one of the latter. Dr. Hunter, by an exhaustive process of reasoning, traced out the chain of phenomena, and ascribed the commencement of the whole to the thoroughly septic condition of his own hands after the bad cases of erysipelas and abscess first alluded to. He described the extreme precautions he took as to cleanliness, and their good effect when once undertaken.

Dr. Simpson thought the society, and indeed the whole profession, were indebted to Dr. Hunter for his paper. It certainly required a great deal of courage to bring forward the series of disastrous cases so admirably detailed. The question now was, were we to retain the term puerperal fever? In the discussion previous to Dr. Hunter's paper there was a variety of fevers in women, all puerperal, because they occurred in the puerperal state. Thus, when typhoid fever or small-pox laid hold of a puerperal woman, there was danger of death, because she had never had them before. In one case of a lady, who had been sedulously guarded from infantile diseases, an attack of measles in her thirteenth confinement proved fatal in a few days. Now, were we to look on puerperal fever as identical with erysipelas? Sometimes the erysipelatous poison coming into contact with the vaginal or other canals caused symptoms similar to those arising after a surgical operation. Then there was the group of cases so well brought forward by Dr. Hunter, where the surgeon got impregnated with a poison which would give a surgical patient a fever with local manifestations from the introduction of poisons into a wound. This, as taught by the late Sir James Simpson, should be held as puerperal fever when the patient was a puerperal woman. There were two things, however, required from Dr. Hunter; viz., post-mortem examinations of the women who had died, and also of the fatal surgical case. This would, no doubt, have shown lymphatic inflammation, phlebitis, thrombosis, and metastatic inflammation. He had collected for his late uncle, in the dissecting-rooms at Vienna, the results of post-mortem examinations of patients dying after puerperal fever and after surgical operations. The results in both classes of cases were the same, especially where the surgical operation had been on the abdomen. The great danger in a puerperal patient lay in her condition. It would have been interesting to know the health of the puerperal women in the district at the time of Dr. Hunter's fatal cases, as it would have added to the value of his paper. He had undoubtedly carried a morbific agent; and it was, therefore, important to watch the kind of source from which such an agent might arise. Dr. Hunter had done so in his cases, but it might come from less striking sources. Thus, in a case of his